

## Section of Ophthalmology.

President—Mr. ERNEST CLARKE, C.V.O., F.R.C.S.

---

### CLINICAL MEETING.

*Held at the Central London Ophthalmic Hospital, Judd Street, December 10, 1926.*

---

### Peculiar Opacity of Cornea.

By LESLIE PATON, F.R.C.S.

I SAW this patient a week ago. He had then been under treatment for over two years as a case of subacute glaucoma. I think the diagnosis was based on the occurrence of haloes. I could not myself find evidence of glaucoma except for these haloes. The tension was somewhat subnormal, the anterior chambers were fairly deep, there was no trace of venous pulsation, nor of cupping of the disc, and no real evidence of any condition pointing to glaucoma. The vision was good, considering the amount of opacity in the cornea, namely,  $\frac{5}{8}$  with correction in the right eye,  $\frac{6}{8}$  in the left eye, but he has not used the left eye for a long time. He has a persistent pupillary membrane in the left eye. The explanation of the haloes lies in the deep haze in the cornea, which is the result of old keratitis profunda.

The main reason for bringing the case is to obtain the opinions of the slit-lamp experts on it. Most of us are at present only amateurs in the use of the slit-lamp. I would like opinions on the curious appearance of haze in the left eye, not exactly on Descemet's membrane, but in the very deep layers of the substantia propria. There are curious little rosettes of spindles, the spindles having a double contour. They are not, I think, crystalline, and the position is against them being folds in Descemet's membrane. It is these rosettes of spindles forming a mosaic in the very deep layers of the cornea which perplex me, and I would like to know if any Members have seen anything like it before. I have not.

### Recurrent Intra-Ocular Hæmorrhage in a Young Male.

By H. M. GILMOUR, L.R.C.P.Lond., M.R.C.S.Eng. (Ipswich).

PATIENT, a farm labourer, aged 23, who saw me on September 23, complaining that vision had failed three weeks previously. Right vision =  $\frac{1}{12}$ , left vision =  $\frac{6}{8}$ .

Right eye shows recent blood-clot in the vitreous and a retinal detachment below. Left eye has a mass of fibrous tissue in the vitreous, presumably the consequence of hæmorrhage at some former time, no retinal detachment can be demonstrated. In both eyes transillumination is good.

We excluded syphilis, diabetes, nephritis; all the organs were examined and found healthy. No von Pirquet test has been made. Seeking a cause I considered that the most profitable line of inquiry would be along the assumption that a mild infection of the blood was present; some support for this supposition was provided by the fact that the patient during the first three weeks had an intermittent elevation of temperature. The teeth were X-rayed but nothing was shown to be wrong with

*Mayou: Industrial Toxic Amblyopia*

their roots, nor, indeed, did we find any infective focus. The condition is now practically identical with the state in which I first saw him eleven weeks ago.

*Discussion.*—Mr. GRAY CLEGG said he considered that in this patient's left eye there was a detachment of the retina below. Vessels could be seen, and, in addition, vitreous opacities. He wondered whether an altered coagulation point in the patient's blood was the explanation of the hæmorrhages.

Mr. A. L. WHITEHEAD said that some time ago he recorded a case before the Section which was somewhat similar to that shown by Mr. Gilmour. It was that of a young man who had, apparently, the ordinary type of vitreous hæmorrhages. Ultimately, six to twelve months after the onset, he developed a typical tuberculous iritis in one eye. Tuberculin treatment was begun, and the condition began to improve at once. At his worst he had mere perception of light in one eye, and with the other eye he could count fingers a yard away; but after the tuberculin treatment vision in one eye was  $\frac{3}{4}$ , in the other  $\frac{3}{8}$ . The iritis cleared up with the exception of some strands and patches of retinitis proliferans, which, however, did not interfere with his macular vision. He (Mr. Whitehead) was therefore encouraged to recommend a trial of tuberculin in Mr. Gilmour's case.

**Industrial Toxic Amblyopia.**

By M. S. MAYOU, F.R.C.S.

THIS case is a patient of Mr. Munro, of Ipswich. It has an important aspect from an industrial point of view. He is a farm labourer. His discs are very pale, the vessels are of good size, and he has a large central scotoma, with slightly contracted fields. Vision = H.M. each eye. His occupation is that of spraying fruit trees with a mixture of arsenic, nicotine and lead, and since he started this work his sight has gradually deteriorated; now it only amounts to perception of hand movements. I regard this as a case of nicotine poisoning brought on by the use of the nicotine and other poisons used in the spraying. It appears that while the spraying is in progress the man is in a complete mist of the mixture.

When he first presented himself it was thought the only other possibility was pituitary enlargement. He has been under Dr. Martin, who examined him, with X-rays and otherwise, but can find no alteration of sugar tolerance or any other change indicative of pituitary disease. I made inquiries at the Ministry of Agriculture as to whether similar cases had been reported to them: their reply was in the negative.

Dr. PURDON MARTIN said this patient was first sent to him, as a case of optic atrophy, to be medically examined. He had the history that the patient had been using a nicotine preparation, but the visual fields had not been taken, and several other possibilities were considered. The patient had not the general appearance of a case of pituitary tumour, but the discs were more pale in one half than in the other, and there was the peculiar appearance of skin which patients with pituitary disease often had; it was a soft white skin; there was also a marked deficiency of hair, and the patient had never required to shave more than once a week. For those reasons it seemed that a pituitary condition might at least be a factor. Also, the man had a definitely oxycephalic skull, though he (Dr. Martin) did not know whether it was pathologically so. Oxycephaly was therefore another possible factor. Since then the case had been investigated at the National Hospital, Queen Square, by X-rays and otherwise. The radiograms did not reveal any abnormality in the pituitary fossa, nor was there any disturbance of the blood-sugar curve; the fields of vision showed that the visual disturbance was due to a large central scotoma, and was not of the pituitary type; there were no indications of syphilis. He agreed that the atrophy in this case was probably toxic.